Testimony before the Committee on Ways and Means Hearing on Health Reform in the 21st Century

Prepared for:
The Committee on Ways and Means

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Thank you Chairman Rangel and Ranking Member Camp for the invitation to testify this morning. I am John Pickering, a Principal and Consulting Actuary with Milliman in Seattle, and I appreciate the opportunity to contribute to this healthcare reform dialogue. Milliman is the largest actuarial employer in the country, with offices in approximately 30 US cities. In healthcare, we work with health plans, providers, employer groups, and government entities nationwide.

We recently conducted a study of hospital and physician payment rates among Medicare, Medicaid, and commercial payers at the request of AHIP, the American Hospital Association, the Blue Cross Blue Shield Association, and Premera Blue Cross. I will summarize the findings of our study in my testimony today.

My goal is not to advocate for or against any specific reform proposal, but rather to help inform the debate.

We measure the cost shift as the change in provider payment that would be required by Medicare, Medicaid, and commercial payers such that all three would pay equivalent rates. Together, these three main payer types must also cover the unpaid costs of services for the uninsured.

Chart 1 presents our findings for hospitals, based on 2006 data. We estimate that on average, hospitals had a -9.4% margin on Medicare patients, a -14.7% margin on Medicaid patients, a 23.1% margin on commercial patients, and a -25.1% margin on uninsured and other government patients. These combined for an overall operating margin of 3.8%. The Medicare/Medicaid/commercial subtotal operating margin was 6.4%.

Chart 1
2006 Hospital Operating Margins
in billions

	(A)	(B)	(C)=A+B	(D)	(E)=C+D	(F)=E/C	
	Patient Revenue	*Other Operating Revenue*	*Total Revenue*	*Operating Expense*	*Gain/ (Loss)*	*Operating Margin*	*Cost Shift*
Medicare	$195.7	$10.0	$205.7	($225.1)	($19.4)	-9.4%	
Medicaid	$67.8	$4.8	$72.6	($83.3)	($10.7)	-14.7%	$51.0
Commercial	$276.4	$10.7	$287.1	($220.6)	$66.5	23.1%	
Subtotal	$539.9	$25.6	$565.5	($529.1)	$36.4	6.4%	
Uninsured & Other Gov't	$43.7	$6.7	$50.5	($63.2)	($12.7)	-25.1%	
Operating Total	$583.6	$32.3	$616.0	($592.3)	$23.7	3.8%	

In order for each hospital to achieve consistent margins on Medicare, Medicaid, and commercial business, we estimate Medicare and Medicaid combined would have needed to pay an additional $51 billion, and commercial payers would have paid $51 billion less. This would amount to an 18% reduction in commercial payment rates.

Chart 2 presents our findings for physicians, based on 2007 data. The values in Chart 2 represent relative payment levels. 1.0 represents the weighted average of all three payers. We estimate that Medicare paid 11% less than the average, Medicaid paid 40% less than the average, and commercial payers paid 14% more than the average.

Chart 2
2007 Physician Relative Payment Levels

Medicare	0.89
Medicaid	0.60
Commercial	1.14
Average	1.00

In order for each to pay the average rate, Medicare and Medicaid would have needed to pay an additional $38 billion, and commercial payers would have paid $38 billion less. This would represent a 12% reduction in commercial payment rates.

Chart 3 summarizes our cost shift estimates. In total, we estimate the cost shift burden on commercial payers is approximately $89 billion. This calculation of the cost shift is revenue neutral to hospitals and physicians. We have held total payment to providers constant, but reallocated the source.

Chart 3
Medicare & Medicaid Cost Shift
in billions

	Medicare	*Medicaid*	*Commercial*	*Total*
Hospital	($34.8)	($16.2)	$51.0	$0.0
Physician	($14.1)	($23.7)	$37.8	$0.0
Total	($48.9)	($39.9)	$88.8	$0.0

These cost shift estimates are not based on our opinion of an appropriate payment level, but rather are a measurement of the magnitude of current differences in rates.

The impact of the cost shift varies geographically and by provider. Hospitals vary in their patient mix; those with higher percentages of Medicare, Medicaid, and uninsured patients face a bigger burden. Hospitals also vary in their cost efficiency. Some hospitals are able to make a positive margin on Medicare.

The payment rate differential puts pressure on commercial premiums. Chart 4 presents our estimates of the cost shift impact on a typical family of four in an employer sponsored PPO plan. The left side of the chart presents the total annual healthcare cost for this family, including premium and cost sharing, such as deductibles, copays, and coinsurance, and split between amounts paid by the employer and the family.

Chart 4
Annual Medicare & Medicaid Cost Shift Burden for Typical Family of Four in a Commercial PPO Plan

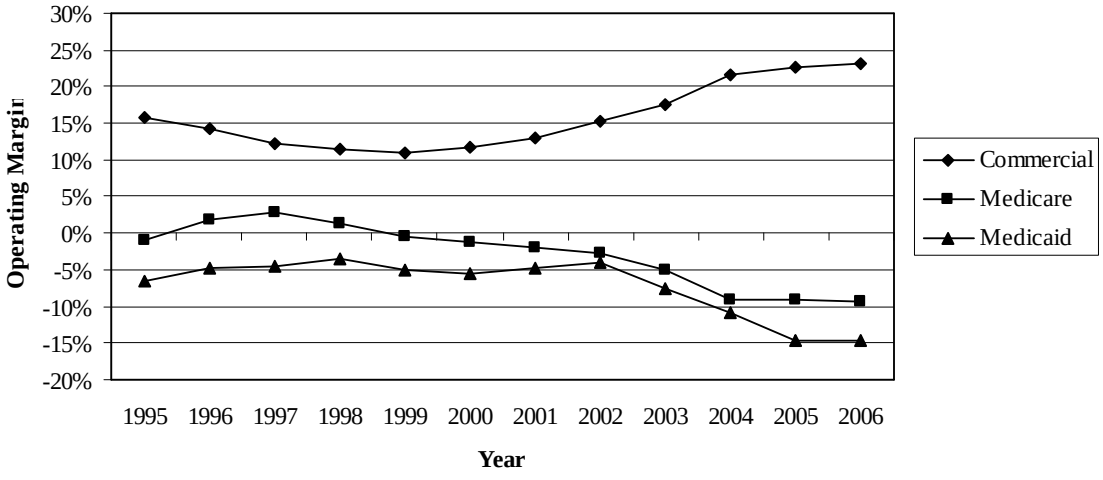
	Total Annual Cost[1]			Portion Due to Cost Shift		
		Cost			*Cost*	
	Premium	*Sharing*	*Total*	*Premium*	*Sharing*	*Total*
Employer	$10,481		$10,481	$1,115		$1,115
Subscriber	$3,731	$2,420	$6,151	$397	$276	$673
Total	$14,212	$2,420	$16,632	$1,512	$276	$1,788
% of Total				10.6%	11.4%	10.7%

1) Based on the 2007 Milliman Medical Index, with an 85% loss ratio assumed.

The right side of the chart represents the amount that is due to the cost shift. In total, we estimate that if the cost shift were eliminated, healthcare spending for this family of four would be reduced by almost $1,800 per year, or 10.7%.

We were able to evaluate hospital operating margins going back to 1995. Chart 5 presents the results. Commercial margins bottomed in 1999, and have increased since. Medicare margins peaked in 1997, and have since declined. Medicaid margins began declining in 2003.

Chart 5
Hospital Operating Margins by Year



The rising commercial margin indicates that the trend in payment from commercial payers has exceeded the trend in hospital operating cost. This excess trend has been one component in commercial premium trend in recent years.

While my comments today are focused on the financing of healthcare, I also want to acknowledge the importance of improving efficiency in the delivery system. To be successful in the long term, reform must address both the financing of care and the cost efficiency and quality of care delivered.

Thank you.